tiveness in improving symptoms rather than changing the FEV_1 has resulted in recommending these drugs in patients who remain symptomatic despite the use of short acting bronchodilators. An important point is the recommendation to assess the response to therapy in terms of symptoms and exercise tolerance. The use of inhaled corticosteroids is clarified, based on recent evidence that they reduce exacerbations in patients with an FEV_1 of less than 50% predicted and a history of one or more exacerbations in the preceding year.

The role of combinations of long acting bronchodilators and corticosteroids is defined less clearly and is already out of date with respect to recently published data[6]—a problem with all guidelines. This highlights the need to have a mechanism in place for regular updates of guidelines.

A novel statement in the guideline relates to the use of mucolytic drugs, which have not been used or licensed for chronic obstructive pulmonary disease in the United Kingdom. A review of the literature indicates that mucolytics, and particularly the mucolytic and antioxidant N-acetylcysteine, are effective in reducing exacerbations and improving symptoms in patients with chronic bronchitis and provides some evidence to support its efficacy in this condition. Again this evidence will soon be out of date with the forthcoming publication of the randomised controlled trial of N-acetylcysteine in chronic obstructive pulmonary disease. This trial shows no effect of the drug on FEV_1 decline but a reduction in overinflation in patients with severe chronic obstructive pulmonary disease and in the exacerbation rate in patients who are not treated with inhaled corticosteroids (Marc Decramer, personal communication, 2004).

The role of pulmonary rehabilitation is firmly established in the guideline, and this firm recommendation of its efficacy will hopefully improve the woeful lack of provision of this treatment in the United Kingdom. The provision of oxygen therapy has been updated in line with the advice of the published report by the Royal College of Physicians[7] and includes recommendations for ambulatory oxygen, which will hopefully be available for prescription in the very near future.

The advice in the NICE guideline on exacerbations is very similar to recommendations in other guidelines on, for example, the use of oral corticosteroids and of oxygen therapy and antibiotics. Although the lack of evidence for intravenous theophylline is interpreted as being the reason for not altering the practice of giving intravenous theophylline when treatment with bronchodilators fails to show an improvement in an exacerbation, most other guidelines indicate that evidence is lacking for the safe use of theophylline, and it is therefore not recommended.

The effectiveness of non-invasive ventilation for acute respiratory failure, which complicates exacerbations of chronic obstructive pulmonary disease, is given prominence, although specific recommendations on when to introduce this treatment are not clear. Nurse led or supported discharge schemes for exacerbations of chronic obstructive pulmonary disease are recommended in view of the evidence based on several randomised controlled trials.

The NICE guideline will help to clarify, standardise, and improve treatment of chronic obstructive pulmonary disease. Hopefully, it will ensure the provision of treatment options such as non-invasive ventilation, supported discharge, and rehabilitation.

William MacNee *professor of respiratory and environmental medicine*

Edinburgh Lung and the Environment Group Initiative (ELEGI), Colt Research Laboratories, Medical Research Council Centre for Inflammation Research, University of Edinburgh, Edinburgh, Scotland EH8 9AG
(w.macnee@ed.ac.uk)

Competing interests: WMcN has been reimbursed by GlaxoSmithKline, and Boehringer-Ingelheim for attending several conferences. He has been paid for speaking at medical conferences organised by GlaxoSmithKline, AstraZeneca, Boehringer-Ingelheim, and Zambon. He has received funding for research from Pfizer, GlaxosmithKline, and SMB Pharmaceuticals but not directly related to any of the drugs discussed in the article.

1 Fabbri LM, Hurd SS. Global strategy for the diagnosis and management and prevention of COPD. 2003 Update. *Eur Respir J* 2003;22:1-2.
2 National Collaborating Centre for Chronic Conditions. Chronic obstructive pulmonary disease. National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care. *Thorax* 2004;59(suppl 1):1-232.
3 British Thoracic Society Guidelines for the management of chronic obstructive pulmonary disease. *Thorax* 1997;52(suppl 5):s1-26.
4 Agusti AG. Systemic effects of chronic obstructive pulmonary disease. *Novartis Found Symp* 2001;234:242-9.
5 Celli BR, Cote CG, Marin JM, Casanova C, Montes de Oca M, Mendez RA, et al. The body-mass index, airflow obstruction, dyspnea, and exercise capacity index in chronic obstructive pulmonary disease. *N Engl J Med* 2004;4:1005-12.
6 Calverley PM, Boonsawat W, Cseke Z, Zhong N, Peterson S, Olsson H. Maintenance therapy with budesonide and formoterol in chronic obstructive pulmonary disease. *Eur Respir J* 2003;22:912-9.
7 Royal College of Physicians. *Domiciliary oxygen therapy services clinical guidelines and advice for prescribers*. London: Royal College of Physicians, 1999.

Delivering mental health services for a diverse society

We need to marry policy and practice

The presentation, management, and outcome of mental disorders differ between ethnic groups.[1–3 w1] The most consistent findings are that African-Caribbeans with mental health problems are disproportionately found in forensic, psychiatric, and prison populations and among compulsorily detained patients.[2 3] They are more likely to receive antipsychotic medication and less likely to be offered psychotherapy.[4–5 w2] Rates of suicide are also higher among some South Asian women and young people of Caribbean origin.[6] These disparities have several causes, but it is difficult not to consider the lack of a coordinated and effective response to them as evidence of institutional racism in mental health and allied services.[7–8 w3] In response to the disparities and

Additional references w1-w5 appear on bmj.com

BMJ 2004;329:363–4

the demands of service users for action,[9] the Department of Health recently launched two policy frameworks: *Inside Outside*, a new strategy for England,[10] and a consultation document, *Delivering race equality: a framework for action*.[11] Unfortunately these two documents differ in their focus and emphasis.

Two frameworks and two approaches

The publication of *Inside Outside* represents a landmark in mental health care in the United Kingdom and was developed over two years of extensive consultation with stakeholders. It takes an antidiscriminatory stance and aims to reduce and eliminate ethnic inequalities in the service users' experience of mental health services and clinical outcomes, develop a mental health workforce that is capable of delivering effective mental health services to a diverse population, and build capacity within communities for dealing with mental illness by deploying 500 community development workers. A cultural capability framework aims to tackle institutional discrimination while motivating and educating the workforce to improve clinical practice with diverse cultural groups.[w4]

Delivering race equality was expected to be the implementation guide to *Inside Outside*. However, it has changed the emphasis from clinical effectiveness and equity to strategic and organisational change. In *Delivering race equality*, the need to be compliant with the Race Relations (Amendment) Act is expected to convince trusts to tackle disparities.[11 w5] The document identifies three priorities as the building blocks for service change: ethnic monitoring, appropriate and responsive services, and community engagement. It also promotes training in race relations. The emphasis on race as a focus of reform may well cause problems. It could narrow the aspirations of service developers so that they target racial equality while ignoring the diverse needs of different cultural groups within a racial group. It may encourage outdated race based solutions where more subtle cultural interactions are the key to solving problems. It also runs the risk of excluding white minority groups such as the Irish. It provides no explicit guidance on how to improve clinical services. Stakeholders are requested to offer their opinions on barriers to improvement in care and the types of services they would consider helpful in three areas: acute inpatient care, pathways to care, and prevention of suicide.

During the preparation of *Inside Outside*, extensive consultations were completed. *Delivering race equality* therefore runs the risk of producing consultation fatigue and giving the impression that the views of ethnic minorities were not taken on board initially, as the findings of *Inside Outside* have yet to be implemented. Users of services who come from ethnic minorities want and demand change in NHS provision. They may see *Delivering race equality* as another strategic plan that fails to have any obvious clinical impact.

Clinical effectiveness and cultural capability

The surgeon general's report from the US Department of Health and Human Services gave recommendations for both policy and practice, based on comprehensive analysis of the international literature.[5] In the United States policy moved towards a health promotion model and included culturally competent practitioners, integration between primary and secondary mental health care, and tackling stigma and discrimination.[5 w4] Marrying the strategic direction of *Delivering race equality* with changes in organisation and clinical practice of *Inside Outside* is crucial. The organisational changes promoted by both policy frameworks and the drive towards better data on disparities in *Delivering race equality* are welcome. Better data on the effectiveness of different clinical approaches for distinct cultural groups are needed to support future policy and service initiatives. But how data or organisational changes will change practice without specific workforce development is difficult to see.

The cultural capability framework in *Inside Outside* could deliver this by promoting education and development of skills in the organisational context of antidiscriminatory practice. Cultural capability entails an antidiscriminatory approach to evidence based practice, development of clinical skills so that practitioners can work in culturally acceptable ways despite the absence of specific evidence, and the delivery of an organisational environment that does not promote institutional disparities. In this light an action plan to motivate and then equip professionals with the necessary skills seems vital in order to eradicate inequalities. Clear guidance on individual as well as institutional change will be required to translate both policy documents into action that addresses inequalities in provision of service.

Kamaldeep Bhui *professor of cultural psychiatry and epidemiology*

Institute of Community Health Sciences, Queen Mary University of London, London E1 4NS (k.s.bhui@qmul.ac.uk)

Kwame McKenzie *senior lecturer in transcultural psychiatry*

Royal Free and University College School of Medicine, University College London, London NW3 2PF

Paramjit Gill *senior lecturer*

Department of Primary Care and General Practice, University of Birmingham, Birmingham B15 2TT

Competing interests: KB was part of the external reference group for *Inside Outside* and contributed a paper on cultural capability but did not write the strategy.

1 Cochrane R, Sashidharan S. *Ethnicity and health: reviews of the literature and guidance for purchasers in the areas of cardiovascular disease, mental health, and haemoglobinopathies*. York: University of York, 1996:105-26 (part 3).
2 Bhui K, Stansfeld SA, Hull S, Priebe S, Mole F, Feder G. Ethnic variations in pathways to specialist mental health care: a systematic review. *Br J Psychiatry* 2003;182:5-16.
3 Coid J, Petruckevitch A, Bebbington P, Brugha T, Bhugra D, Jenkins R, et al. Ethnic differences in prisoners. 1: criminality and psychiatric morbidity. *Br J Psychiatry* 2002;181:473-80.
4 McKenzie K, Samele C, Van Horn E, Tattan T, Van Os J, Murray R. Comparison of the outcome and treatment of psychosis in people of Caribbean origin living in the UK and British Whites. Report from the UK700 trial. *Br J Psychiatry*. 2001;178:160-5.
5 US Department of Health and Human Services. *Mental health: culture, race, and ethnicity—a supplement to mental health: a report of the surgeon general*. Rockville, MD: US Department of Health and Human Services, Substance, Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.
6 Raleigh VS. Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales. *Ethnicity Health* 1996;1:55-63.
7 De Wildt G, Gill P, Chudley S, Heath I. Racism and general practice—time to grasp the nettle. *Br J Gen Pract* 2003;53:180-2.
8 Bhopal R. Racism in medicine. The spectre must be exorcised. *BMJ* 2001;322:1503-4.
9 Trivedi P. Racism, social exclusion and mental health: a black user's perspective. In: Bhui K, ed. *Racism and mental health*. London: Jessica Kingsley, 2002:71-88.
10 National Institute of Mental Health-England. *Inside outside. Improving mental health services for black and minority ethnic communities*. London: DoH, 2003. www.nimhe.org.uk/downloads/inside_outside.pdf (accessed 16 Feb 2004).
11 Department of Health. *Delivering race equality: a framework for action*. London: DoH, 2003. www.doh.gov.uk/deliveringraceequality/77951-del_race_equality.pdf (accessed 16 Feb 2004).